Grand Traverse Family Vision

125 E South Airport Rd Traverse City, MI 49686 (231) 252-7015 grandtraversefamilyvision.com

Welcome to our practice

Contact Information

First Name_____ Last Name_____ Middle Initial_____

Address_____ City_____

State_____ Zip Code _____ Date of Birth _____

Mobile Phone (____)_____ Home Phone (____)_____

email address _____ (only used for office communications)

* **Please read the statements below, and then sign, indicating that you have read and understand both statements.**

Patient Authorization

* I authorize the release of any information necessary to process any claim with my insurance company. I authorize payment directly to my doctor for services rendered. I understand that if my insurance does not pay for the services I request, I am responsible to pay for the services I received.

Privacy Practices Acknowledgement

* The privacy policy is available at www.grandtraversefamilyvision.com and/or in paper form given during check-in for appointments. I have read and I understand the privacy practices agreement provided, and have been given ample time to review the information. I give permission to Christopher Gilmartin, OD, Inc to contact me via email or cell phone number (if provided) for office-related communication, such as appointment reminders.

Patient / Guardian Signature _____ **Date** _____

Insurance Information Sheet

*** If you will not be using any insurance, please skip this page ***

The type of insurance you use for your exam depends on the reason for your visit. If you are coming in for a routine checkup to update your glasses or contact lens prescription, we are obligated to use different procedure codes than if you are coming in for a medical purpose to check for issues like diabetes, monitor cataracts, manage dry eye syndrome, etc. Our office does not set these rules, but we do have to follow them.

If you would like to use your insurance, please fill out the information below for the insurance plan(s) you have and we will be happy to check your benefits. Please circle the name of your plan, if you see it listed, or circle "other" and fill in the name of your plan.

VISION (OPTICAL) INSURANCE: MES Spectera VSP EyeMed ADN

Other _____

Primary subscriber: first name _____ last name _____ DOB _____

ID: _____ Last 4 of SS (VSP only): _____

*** *If you have VSP through Blue Cross Blue Shield, please fill in the primary subscriber's BCBS ID number* ***and*** *the last 4 of the primary subscriber's social security number* ***

MEDICAL INSURANCE: None Medicare BCBS Priority Health United Healthcare Cigna

Other _____

Primary subscriber: first name _____ last name _____ DOB _____

ID : _____ ID : _____

*** *If you have Medicare Advantage, please circle Medicare and your supplemental insurance and include* ***both*** *ID numbers* ***

History Form

Do you wear glasses? Y / N **Do you wear contacts?** Y / N

If yes, how are your glasses and/or contacts working?

My vision is fine Blurry far away Blurry up close Blurry at computer

Comments about my vision:_____

_____

Your Eye History

1) How long ago was your last eye exam? 1 yr 2 yr 3 yr 4 yr 5 yr other _____
2) Have you ever had any eye surgery? (Lasik, PRK, RK, corneal transplant, etc) Y / N

_____

3) What type of glasses do you wear? none / distance only / bifocals / progressives / reading glasses
4) Do you ever struggle to see up close? Y / N
5) Do you do any sports or activities with special vision requirements? Y / N _____
6) Do you currently wear contact lenses? Y/ N If yes, what brand? _____
7) If not, are you interested in your contact lens options? Y / N

Your Medical History

8) Do you have a history of smoking cigarettes? Never smoked / Current smoker / Past smoker
9) Please list any chronic medical conditions: (diabetes, high blood pressure, autoimmune disorders)

_____

11) Please list any medications you are currently taking: _____

_____

12) Please list any allergies to medications (penicillin, sulfa, tetracycline, codeine, etc):

_____

Family Eye & Medical History (___ mark "X" if no changes since last examination with us)

1) Any family history of glaucoma, macular degeneration, cataract, retinal detachment? Y/ N
2) Please list any other eye problems that run in your family_____

Office use: reviewed by: _____ date: